

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives; and

"(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

"(2) The written information described in paragraph (1)(A) shall be provided to an adult individual —

"(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

"(B) in the case of a nursing facility, at the time of the individual's admission as a resident,

"(C) in the case of a provider of home health care or personal care services, in advance of the individual coming under the care of the provider,

"(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

"(E) in the case of a health maintenance organization, at the time of enrollment of the individual with the organization.

"(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive."

"(4) In this subsection, the term 'advance directive' means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(b) Conforming Amendments. —

(1) section 1903(m)(1)(A)(42 U.S.C. 1396(b)(m)(1)(A)) is amended —

(A) by inserting "meets the requirement of section 1902 (w)" after "which" the first place it appears, and

(B) by inserting "meets the requirement of section 1902(a) and" after "which" the second place it appears.

(2) Section 1919(c)(2) of such Act (42U.S.C. 1396r(c)(2)) is amended by adding at the end the following new subparagraph:

"(E) Information respecting advance directives. — A nursing facility must comply with the requirement of section 1902(w) (relating to maintaining written policies and procedures respecting advance directives)."

(c) Effective Date. — The amendments made by this section shall apply with respect to services furnished on or after the first day of the first month beginning more than 1 year after the date of the enactment of this Act.

(d) Public Education Campaign. —

(1) In General. — The Secretary, no later than 6 months after the date of enactment of this section, shall develop and implement a national campaign to inform the public of the option to execute advance directives and of a patient's rights to participate and direct health care decisions.

(2) Development and Distribution of Information. — The Secretary shall develop or approve nationwide informational materials that would be distributed by providers under the requirements of this section, to inform the public and the medical and legal profession of each person's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the existence of advance directives.

(3) Providing Assistance to States. — The Secretary shall assist appropriate State agencies, associations, or other private entities in developing the State-specific documents that would be distributed by providers under the requirements of this section. The Secretary shall further assist appropriate State agencies, associations, or other private entities in ensuring that providers are provided a copy of the documents that are to be distributed under the requirements of the section.

(4) Duties of Secretary. — The Secretary shall mail information to Social Security recipients, add a page to the medicare handbook with respect to the provisions of this section.

PROVIDED COURTESY OF THE NATIONAL HEALTH
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PRACTICAL CONSIDERATIONS FOR HEALTHCARE PROVIDERS REGARDING THE IMPLEMENTATION OF THE PATIENT SELF- DETERMINATION ACT OF 1990

OFFICIAL

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Healthcare institutions subject to the patient self-determination provisions of OBRA 1990 (the "Act") will need to address a number of issues regarding implementation of the Act. Some of these questions involve interpreting the language of the Act itself and, when issued, regulations to be promulgated by the Health Care Financing Administration (HCFA), (the "Regulations"). Others involve deciding whether it is advisable to take measures technically not mandated under the Act, but which may logically flow from these requirements.

Set forth below are a number of issues commonly raised by healthcare institutions making preliminary plans for compliance with the Act. Institutions may derive some comfort from the recognition that they are not alone in having these questions; however, there are not pat answers to most concerns. Lack of definitive guidance is caused by a number of factors, including the relatively broad nature of the Act, the current lack of regulatory guidance and anticipated brevity of the interpretive Regulations, the continuing evolution of State law in many jurisdictions regarding advance directives and the right to terminate life support, and the need to evaluate the Act's requirements in the context of each institution's unique characteristics.

(I) The Act requires *distribution of written information* to certain patients. Many institutions are unclear as to the scope of their responsibilities in implementing this provision.

(a) Written information must have *two components*: (i) a summary of individual rights under State law to make decisions regarding medical care (including the right to refuse or accept medical treatment and execute an advance directive); and (ii) the written policies of the entity regarding implementation of those rights.

(i) The *summary of State law* ultimately should be furnished to providers by a State agency or association, thereby presumably maximizing consistency among institutions. In some jurisdictions, rapid evolution in the law will make it very difficult to compile an accurate, understandable summary.

(ii) Each institution will be required to maintain a *written policy regarding application by it of State law* covering the right to accept or terminate

medical treatment and execute advance directives. Healthcare institutions without such a policy in place will have to draft one. In drafting such a document, some institutions may avail themselves of State-specific form policies distributed by agencies or associations. Thought must be given to which persons or committees are best suited to the task of drafting or approving this policy. This may be especially difficult for nonhospital entities such as nursing facilities and home health agencies, which may not have expertise to address fully these concerns. If State law in this area is confused, formulation of a written policy reflecting the law will be made more difficult.

(b) Written information is to be distributed to *all adults*. The Act makes no provision for distributing written information to an adult patient that is admitted or initially comes under care while incompetent. Unless addressed in the Regulations, institutions will have to decide whether or how to distribute written information in these situations.

(c) Written information, generally stated, must be distributed to the patient *at the time of admission* to a hospital or nursing facility, *or initially upon coming under the care* of a home health agency, hospice or HMO. "Admission" is not defined in the Act, although it might be clarified in the Regulations. If consistent with the Regulation, institutions might consider mailing written information with preadmission materials.

(d) The Act is silent as to exactly *how, or by whom, the written information is to be distributed* to patients. Institutions may wish to consult with other providers already voluntarily making this type of information available to get a sense of the range of options available (i.e., use of social workers, chaplains, designated professional or nonprofessional staff members).

(e) The Act does not instruct an institution how to handle instances in which distribution of written information prompts a *patient request to execute an advance directive*. In other words, institutions are neither required to, nor prohibited from, providing assistance to patients wishing to prepare such a document. Again, preliminary indications are that the Regulations also will not provide a mandate on this issue. As a result, institutions probably will have to decide for themselves whether to decline any involvement in this process, make forms available or

provide more extensive counseling regarding advance directives. If an institution decides to provide some guidance to patients, care must be taken to avoid the appearance of undue influence by institution personnel (this may be especially true in nursing facilities) — for example, by prohibiting employees from witnessing advance directives if this is not already prohibited under State law.

(2) Institutions must *document the patient's medical record to indicate whether an advance directive exists*. The Act does not require that a copy of the advance directive be obtained and made a part of the medical record, although State law regarding advance directives may otherwise impose this obligation upon the attending physician, hospitals, or other providers. Institutions nevertheless might decide that the advance directive should be made a part of the medical record, with provisions for confirming its continued validity upon any re-admission or renewal of services.

(3) The Act mandates that institutions provide *education to the staff and the community* regarding advance directives issues. It is important to note that these programs can be provided by a number of different institutions acting collectively.

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